

# ISSUE PAPER — CONNECTICUT ADDENDUM B

## State of Connecticut Hospital Payment Modernization

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### Overview

To support the modernization of hospital payments in the State of Connecticut (CT), the Connecticut Department of Social Services (DSS) will be implementing ambulatory payment classification (APC) grouper software to process outpatient hospital claims. An integral component of the APC process is the assignment of the APC group and the APC status indicator at the procedure code level. The Centers for Medicare and Medicaid Services (CMS) publishes this information in Medicare's Addendum B, a detailed list, by procedure code of APC group, status indicator, relative weight and payment rate, and updates it each quarter. In keeping with one of DSS' goals for the hospital payment modernization project of mirroring Medicare policy, DSS utilized Medicare's Addendum B as the basis of developing the Addendum B for CT Medicaid. There are instances, however, where CT-specific policy is more appropriate. Mercer worked closely with DSS to develop the CT version of Addendum B, which documents the APC groups, status indicators and relative weights adopted by DSS for the APC methodology.

### Discussion

CT Medicaid's APC processing will be based on the CT version of Addendum B which is derived from Medicare's Addendum B. The differences between the CT version of Addendum B and the Medicare version of Addendum B primarily involve service coverage. In many cases, DSS pays for services that are not covered by Medicare, for example, contraceptive services (J7300-J7307). There are also some cases where DSS does not cover services covered by Medicare, such as infertility treatments. This paper describes the process used to develop the CT version of Addendum B followed by a description of the CT Addendum B and how those values will be used to process Medicaid outpatient claims once the APC methodology is implemented. A table showing fields, field descriptions, and valid values for CT Addendum B can be found in Appendix A.

### Initial Review Process

Utilizing Medicare's 2015 Addendum B as a starting point, the following steps were completed to customize a CT version of Addendum B:

1. Added CT-specific columns: Payment Type and CT Fee Schedule.
2. Removed Medicare payment related columns since they are not needed for Medicaid processing.

3. Inserted default values of “APC” or “No” in the Payment Type field based on the values of the status indicator.
4. Reviewed procedure codes with value of “No” in the Payment Type field to determine if any of these codes are payable under CT Medicaid policy:
  - A. The Payment Type field was updated to “FS” (fee schedule) if the procedure code was determined to be payable via CT fee schedule.
  - B. The appropriate fee schedule value was then listed in the CT Fee Schedule field.
    - i. An example of this type of update is procedure code 77057 (Mammogram screening). The payment type is FS and the fee schedule value is Physician and Radiology fee schedule.
5. Reviewed procedure codes with value of “APC” in the Payment Type field to identify any that are in conflict with CT Medicaid policy. If the procedure code was determined to be not payable under CT policy, the Payment Type field was updated to “No”. An example of this type of update is procedure code 89258 (cryopreservation; embryo(s)). While Medicare APCs cover this code, it is not covered in the Connecticut Medicaid program.
6. Identified any additional payment exceptions based on CT payment decisions and updated the Payment Type field to “RCC” (revenue center code), “L1” (lab fee schedule if modifier L1), “MP” (manually priced), or “TBD” (to be determined), as appropriate.

### **Update Process**

Each quarter, DSS will review the procedure codes for which a change to the Medicare Addendum B is identified to determine if an update to the CT Addendum B is warranted. The updates will be applied retroactively to claims processed since the effective date to allow for variations in the timing of receiving the Medicare information and completing the CT review process. Prior to APC implementation, the CT version of Addendum B will be updated based on the most recent version of Medicare Addendum B.

### **Conclusion**

The CT version of Addendum B provides necessary documentation of CT-specific payment approaches for outpatient hospital services at the procedure code level. The maintenance of this key document will be ongoing each quarter to ensure any changes in Medicare APC payment methodology are taken into consideration.

## Appendix A Field Descriptions for CT Addendum B

Field Label	Field Description	Valid Values
Procedure Code	Five digit CPT or HCPCS code.	See CPT or HCPCS manual.
Short Descriptor	Short description for the procedure code field.	See CPT or HCPCS manual.
Payment Type	Identifies the payment method used by DSS to determine if and how the procedure code will be reimbursed.	<ul style="list-style-type: none"> <li>• APC — reimbursed using APC methodology.</li> <li>• FS — reimbursed based on the CT fee schedule listed in the CT Fee Schedule field.</li> <li>• L1 — reimbursed based on Lab fee schedule if modifier L1 present on the detail.</li> <li>• MP — manually priced.</li> <li>• No — not covered by CT Medicaid (payment denied).</li> <li>• RCC — reimbursed based on RCC pricing.</li> <li>• TBD — to be determined.</li> </ul>
Status Indicator	The status indicator assigned by CMS. If the Payment Type value is APC, the status indicator will process according to CMS/Medicare guidelines.	See Medicare Addendum D1.
APC	The APC group assigned by CMS for that procedure code.	See Medicare Addendum B for APC group and Medicare Addendum A for APC descriptions.
Relative Weight	The relative weight assigned by CMS for the APC group assigned.	See Medicare Addendum A or Addendum B.
CT Fee Schedule	Identifies which fee schedule will be utilized for a given procedure code. Field is blank if service will not be paid using a fee schedule.	See CT Fee Schedule Legend in Appendix B.

## Appendix B

### CT Fee Schedule Legend

<b>Label</b>	<b>Fee Schedule Description</b>
<b>Clinic-BH</b>	Clinic-Behavioral Health fee schedule.
<b>Dialysis</b>	Clinic-Dialysis fee schedule.
<b>FP/OFOUT</b>	For 340B providers, use the Clinic-Family Planning fee schedule. For all others providers, use the Physician Office and Outpatient fee schedule.
<b>LAB</b>	Lab fee schedule.
<b>LAB - ModL1</b>	Lab fee schedule only if modifier L1 is present.
<b>MEDS - DME</b>	MEDS-DME fee schedule.
<b>MEDS - Hearing Aid</b>	MEDS-Hearing Aid/Prosthetic Eye fee schedule.
<b>NDC</b>	NDC — average wholesale price (AWP) minus 16.5%.
<b>OFOUT</b>	Physician Office and Outpatient fee schedule.
<b>PHRAD</b>	Physician Radiology fee schedule.
<b>RCC 771</b>	The procedure code must be billed with RCC 771 and will be reimbursed based on the rate on file for RCC 771.
<b>RCC 901</b>	The procedure code must be billed with RCC 901 and will be reimbursed based on the rate on file for RCC 901.
<b>Rehab/Clinic</b>	Clinic-Rehabilitation fee schedule.
<b>Therapy RCCs</b>	The procedure code must be billed with one of the therapy RCCs (42x, 43x or 44x) and will be reimbursed based on the rate on file for the RCC.